Broken, Loose, or Carious Teeth

These teeth may progress into more severe problems (e.g., dislodging a decayed tooth and swallowing or aspirating it). Although, not emergencies, a dental consult should be considered.

If a Resident has Lost Some or All of His/Her Natural Teeth and Does Not have Dentures (or partial plates)

Staff should consider if the resident has the cognitive ability and motivation to wear dentures.

- Has a dentist evaluated resident for dentures?
- Why doesn't resident use his/her dentures (or partial plates)?
- Are teeth in good repair?
- Do they fit well?
- Are they comfortable to wear when eating or talking?
- Does the resident like the way he/she looks when wearing them?
- Has a dentist evaluated resident for dentures?
- Has a dental hygienist interviewed and made recommendations regarding oral hygiene care?

Exam by Dentist Since Problem Noted

When evaluating a resident with mouth pain or the presence of any of the other trigger signs, check the record to see if a dentist has examined the resident since the problem was first noted.

- Was the current problem addressed?
- What were the recommendations?

Use of Anticoagulants

- Is the resident on coumadin or heparin that would put him/her at risk for bleeding if dental work were necessary?
- Is it noted on the medical record?

Valvular Heart Disease or Prosthesis (e.g., heart valve, false hip, etc.)

- Is either of these conditions present?
- If so are they clearly noted in the medical record so that necessary precautious be taken prior to dental work?

15. DENTAL CARE RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

Dental care or oral health problem suggested if one or more of the following present:

- Mouth Debris (*Dental Care*)
  [L1a = checked]
- Less Than Daily Cleaning of Teeth/Dentures (*Dental Care*)
  [L1f = not checked]

- Mouth Pain (*Oral Health*)
  [K1c = checked]
- Some/All Natural Teeth Lost and Does Not Have or Does Not Use Dentures (*Oral Health*)
  [L1c = checked]
- Broken, Loose or Carious Teeth (*Oral Health*)
  [L1d = checked]
- Inflamed Gums, Oral Abscesses, Swollen/Bleeding Gums, Ulcers, Rashes (*Oral Health*)
  [L1e = checked]

GUIDELINES

Confounding problems to be considered:

- Impaired Cognitive Skills **[B1, B4]**
- Impaired Ability to Understand **[C1, C6]**
- Impaired Vision **[D1]**
- Resists ADL Assistance **[E4e]**
- Impaired Personal Hygiene **[G1j]**
- Motivation/Knowledge **[from observation]**
- Adaptive Equipment for Oral Hygiene **[from record]**
- Dry Mouth from Dehydration **[J1c, d]** or from Medications **[from medication sheet]**

Treatment history/relevant factors:

- Mouth Pain or Sensitivity **[K1c]**
- Presence of Lesions, Ulcers, Inflammation, Bleeding, Swelling or Rashes **[L1e]**
- Broken, Loose or Carious Teeth **[L1d]**
- Natural Teeth Lost/No Dentures **[L1c**]
- Exam by Dentist/Dental Hygienist since Problem Noted **[from record]**
- Use of Anticoagulants **[from record]**
- Valvular Heart Disease or Valvular Appliance **[I3]**

16. RESIDENT ASSESSMENT PROTOCOL: PRESSURE ULCERS

I. PROBLEM

Most nursing facility residents are typically considered to be at risk to develop pressure ulcers (pressure sores, decubitus ulcers, bedsores). Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. However, they are one of the most common, preventable and treatable conditions among the elderly who have restricted mobility. Successful outcomes can be expected with preventive and treatment programs.

Assessment goals are: (1) to ensure that a treatment plan is in place for residents with pressure ulcers; and (2) to identify residents at risk for developing a pressure ulcer who are not currently receiving some type of preventive care program.

II. TRIGGERS

Pressure ulcer present or there is a risk for occurrence if one or more of following present (risk):

- Pressure Ulcer(s) Present *(Present)*[a]
  [M2a = 1, 2, 3, 4]
- Bed Mobility Problem (*Risk*)
  [G1aA = 2, 3, 4, 8][b]
- Bedfast (*Risk*)
  [G6a = checked]
- Bowel Incontinence (*Risk*)
  [H1a = 1, 2, 3, 4]
- Peripheral Vascular Disease (*Risk*)
  [I1j = checked]
- Previous Pressure Ulcer (*Risk*)
  [M3 = 1]
- Skin desensitized to pain or pressure (*Risk*)
  [M4e = checked]
- Daily Trunk Restraint (*Risk*)[c]
  [P4c = 2]

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[a] **Note:** Codes 2, 3, and 4 also trigger on the Nutritional Status RAP.
[b] **Note:** Codes 2, 3, and 4 also trigger on the ADL RAP.
[c] **Note:** This code also triggers on the Falls RAP and Physical Restraints RAP.

III. GUIDELINES

Review the MDS items listed on the RAP KEY for relevance in understanding the type of care that may be required.

Diagnoses, Conditions and Treatments that Present Complications

Consider carefully whether the resident exhibits conditions or is receiving treatments that may either place the resident at higher risk of developing pressure ulcers or complicate their treatment. Such conditions include:

Diabetes, Alzheimer's Disease and Other Dementias - Impairment in cognitive ability, particularly in severe end-stage dementia, can lead to immobility.

Edema - The presence of extravascular fluid can impair blood flow. If prolonged or excess pressure is applied to an area with edema, skin breakdown can occur.

Antidepressants and Antianxiety/Hypnotics - These medications can produce or contribute to lessened mobility, worsen incontinence, and lead to or increase confusion.

Interventions/Programs to Consider if the Resident Develops a New Pressure Ulcer, or an Ulcer Being Treated is Not Resolved

A variety of factors may explain this occurrence; however, they may suggest the need to evaluate current interventions and modifications of the care plan.

- Review the resident's medical condition, medications, and other risk factors to determine whether or not the care plan (for prevention or cure) addresses all potential causes or complications.
- Review the care plan to determine whether or not it is actually being followed (e.g., is the resident being turned often enough to prevent ulcer formation).

Things to Consider if the Resident is at Risk for Pressure Ulcers but is Not Receiving Preventive Skin Care

Even if pressure ulcers are not present, determine why this course of prevention is not being provided to a resident with risk factors.

- Is the resident new to the unit?
- Do few or many risk factors for the development of pressure ulcers apply to this resident?
- Are staff concentrating on other problems (e.g., resolution of behavior problems) so that the risks pressure of ulcers are masked?

16. PRESSURE ULCERS CARE RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

Pressure ulcer present or risk for occurrence if one or more of following present:

- Pressure Ulcer(s) Present (*Present*)[a]
  [M2a = 1, 2, 3, 4]
- Bed Mobility Problem (*Risk*)
  [G1aA = 2, 3, 4, 8][b]
- Bedfast (*Risk*)
  [G6a = checked]
- Bowel Incontinence (Risk)
  [H1a = 1, 2, 3, 4]
- Peripheral Vascular Disease (*Risk*)
  [I1j = checked]
- Previous Ulcer (*Risk*)
  [M3 = 1]
- Skin Desensitized to Pain or Pressure (*Risk*)
  [M4e = checked]
- Daily Trunk Restraint (*Risk*)[c]
  [P4c = 2]

GUIDELINES

Other factors that address or may complicate treatment of pressure ulcers or risk of ulcers:

- **Diagnoses or Conditions:**

  Diabetes **[I1a]**, Alzheimer's Disease **[I1q],** Other Dementia **[I1u]**, Hemiplegia/ Hemiparesis **[I1v]**, Multiple Sclerosis **[I1w]**, Edema **[J1g]**

- **Interventions/Programs:**

  - Pressure Relieving Chair/Beds **[M5a, M5b]**
  - Turning/Repositioning **[M5c]**
  - Nutrition or Hydration Program to Manage Skin Care Problems **[M5d]**
  - Ulcer Care **[M5e]**
  - Surgical Wound Care/Treatment **[M5f]**
  - Application of Dressings (With or Without Topical Medications) Other Than to Feet **[M5g]**
  - Application of Ointment/Medications (Other Than to Feet) **[M5h]**
  - Preventative or Protective Skin Care (Other Than to Feet**) [M5i]**
  - Preventative or Protective Foot Care **[M6e]**
  - Application of Dressings to Feet (With or Without Topical Medications**) [M6f]**
  - Use of Restraints **[P4c,d,e]**

- **Medications:**

  - Antipsychotics **[O4a]**
  - Antianxiey **[O4b]**
  - Antidepressants **[O4c]**
  - Hypnotics **[O4d]**

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[a] **Note:** Codes 2, 3, and 4 also trigger on the Nutritional Status RAP.

[b] **Note:** Codes 2,3 and 4 also trigger on the ADL RAP.

[c] **Note:** This code also triggers on the Falls RAP and Physical Restraints RAP.

17. RESIDENT ASSESSMENT PROTOCOL: PSYCHOTROPIC DRUG USE

I. PROBLEM

Psychotropic drugs (i.e., drugs that affect the mind, emotions, or behavior) are among the most frequently prescribed agents for elderly nursing facility residents. Studies in nursing facilities have shown that 35% to 65% of residents receive psychotropic medications. When used appropriately and judiciously, these medications can enhance the quality of life of residents who need them. For instance, greater than 70% of patients with major depression respond to single antidepressant treatment with complete remission of symptoms. However, all psychotropic drugs have the potential for producing undesirable side effects or aggravating problematic signs and symptoms of existing conditions. An important example is postural hypotension, that may be caused by some commonly prescribed psychotropic medications, and which can be serious or life threatening. Another example is acute confusion (delirium), which can be caused by a single drug, or by the interaction of two or more drugs, and can occur just as easily with prescription or non-prescription (i.e., "over-the counter") medications. Independent risk factors for development of delirium include older age, concurrent medical illness, greater number of medications and the presence of dementia.

Maximizing the resident's functional potential and well-being while minimizing the hazards associated with drug side effects are important goals of therapy. In reviewing a psychotropic drug regimen there are several rules of thumb:

- Evaluate the need for the drug (e.g., consider intensity and quality of distress, response to nonpharmaclogic interventions, pros and cons of drug treatment vs. no drug treatment). Distinguish between treating specific diagnosed psychiatric disorders and treating symptoms. Specific psychiatric disorders (e.g., schizophrenia, major depression) have specific drug treatments with published guidelines for dosage and duration of treatment. However, a recorded diagnosis of a psychiatric disorder does not necessarily require drug treatment if symptoms are not present or are not posing a problem.
- Start low and go slow. If needed, psychotropic drugs should be started at the lowest dosage possible. To minimize side effects, doses should be increased slowly until there is a therapeutic effect, side effects emerge, or the maximum recommended dose is reached. Keep in mind that many elders may show a clinical response and possibly complete resolution of symptoms at drug doses and intervals lower than those recommended.
- Each drug has its own set of actions and side effects, some more serious than others; these should be evaluated in terms of each user's medical-status profile, including interaction with other medications.
- Consider symptoms or decline in functional status as a potential side effect of medication.
- Remember that any drug, prescription or non-prescription can cause problems in some patients.

II. TRIGGERS

TO BE TRIGGERED, RESIDENT MUST FIRST USE A PSYCHOTROPIC DRUG [Antipsychotic, antidepressant, or antianxiety] [O4a, b, or c = 1-7]. If used, go to RAP review if one or more of following present:

PSYCHOTROPIC TRIGGERS A

Potential for drug-related hypotention or gait disturbances if:

- Repetitive Physical Movement[a]
  [E1n = 1,2]
- Balance While Sitting
  [G3b = 1,2,3]
- Hypotension
  [I1i = checked]
- Dizziness/Vertigo[b]
  [J1f = checked]
- Syncope
  [J1m = checked]
- Unsteady Gait
  [J1n = checked]
- Fell in Past 30 Days[b]
  [J4a = checked]
- Fell in Past 31-180 Days[b]
  [J4b = checked]
- Hip fracture
  [J4c = checked]
- Swallowing Problem
  [K1b = checked]

Potential for drug-related cognitive/behavioral impairment if:[c]

- Delirium/Disordered Thinking
  - Easily Distracted
    [B5a = 2]
  - Periods of Altered Perception or Awareness of Surroundings
    [B5b = 2]
  - Episodes of Disorganized Speech
    [B5c = 2]
  - Periods of Restlessness
    [B5d = 2]
  - Periods of Lethargy
    [B5e = 2]
  - Mental Function Varies Over the Course of the Day
    [B5f = 2]

- Deterioration in Cognitive Status[c]
  [B6 = 2]
- Deterioration in Communication
  [C7 = 2]
- Deterioration in Mood[c]
  [E3 = 2]
- Deterioration in Behavioral Symptoms[c]
  [E5 = 2]
- Depression
  [I1ee = checked]
- Hallucinations
  [J1i = checked]

Potential for drug related discomfort if:

- Constipation
  [H2b = checked]
- Fecal Impaction
  [H2d = checked]
- Lung Aspiration
  [J1k = checked]

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[a] **Note:** This item also triggers on the Mood RAP.
[b] **Note:** These items also trigger on Falls RAP.
[c] **Note:** All of these items also trigger on the Delirium RAP.

III. GUIDELINES

If any of the triggered conditions are present complete the following:

Step One:

Conduct the following reviews:

1. Drug Review [from record]

- Length of time between when the drug was first taken and onset of problem
- Dose of drug and how frequently taken
- Number of classes of psychotropics taken
- Reason drug prescribed

2. Review Resident's Conditions that Impair Drug Metabolism/Excretion

- Impaired liver/renal function
- Acute condition(s)

- Dehydration

3. Review Behavior/Mood/Psychiatric Status

- Current problem status
- Recent changes in mood and behavior
- Behavior management program
- Psychiatric conditions

Step Two:

Compare the drugs the resident is currently taking with common side effects listed below. Refer to Tables A, B, and C for clarification.

POTENTIAL PSYCHOTROPIC DRUG-RELATED SIDE EFFECTS

Clarifying Information if Hypotension Present

Postural (orthostatic) hypotension (decrease in blood pressure upon standing) is one of the major risk factors for falls related to psychotropic drugs. It is commonly seen with the low-potency antipsychotic drugs (chlorpromazine, thioridizene) and with tricyclic antidepressants. Both classes of drugs have anticholinergic properties. Within each class, drugs with the most potent anticholinergic properties also seem to produce the greatest hypotensive effects. Symptoms of dizziness/vertigo upon sitting or standing from a lying position, syncope (fainting), and falls/fractures, should be seriously considered as potential indicators of psychotropic-drug-induced hypotension. In addition, these symptoms may be due to a disturbance of heart rhythm, which could be aggravated by a tricyclic antidepressant. The occurrence of any of the aforementioned symptoms requires assessment of postural vital signs and heart rhythm.

- ***Measurement of Postural Vital Signs -*** Measure blood pressure and pulse when the resident is lying down. Remeasure blood pressure and pulse after the resident has been on his/her feet for one to five minutes (if unable to stand, measure after the resident has been sitting). Occasionally, further drops in blood pressure occur after the person has been up for some time. While a drop of more than 20 mm Hg systolic is always abnormal, it is particularly significant if accompanied by dizziness, loss of balance, or a standing blood pressure of less than 100 mm Hg. A large drop may be clinically significant even if the lower pressure is not abnormally low, particularly in residents who have some degree of cerebrovascular disease.

Clarifying Information if Movement Disorder Present

High Fever AND/OR Muscular Rigidity - Antipsychotic drugs can interfere with temperature regulation, which can lead to the potentially fatal problem of hyperthermia. Also, when high fever is accompanied by severe muscular rigidity, "neuroleptic malignant" syndrome must be suspected. Fever above 103 degrees in a resident on an antipsychotic drug is a medical

emergency because of the disturbed temperature regulation. Even lesser degrees of fever, if accompanied by severe muscular rigidity, are medical emergencies. Temperature must therefore be monitored especially closely in residents on psychotropic drugs with anticholinergic properties. In addition, nonantipsychotic drugs with anticholinergic properties, such as antidepressants, may aggravate fever by impairing sweating.

Parkinson's Disease - Is aggravated by all antipsychotic drugs. At times, it is difficult to know whether parkinsonian symptoms (e.g., tremors, especially of hands; pill-rolling of hands; muscle rigidity of limbs, necks, trunk) are due to Parkinson's disease or to present or recent antipsychotic drug therapy. There should be a strong bias in favor of reducing or eliminating antipsychotic drugs in residents with Parkinson's disease unless there are compelling behavioral or psychotic indications. Antiparkinson drugs should be considered when antipsychotic drugs are clinically necessary in residents with Parkinson's disease.

Five movement disorders are commonly encountered in residents on antipsychotic drugs. All of these disturbances can adversely affect a resident's quality of life as well as increase his/her risk of accidents. The triggered MDS items in Group 2 are signs/symptoms of these disorders. To clarify whether or not the resident is suffering from one of these disorders, all residents on antipsychotic drugs should be periodically screened for the following conditions:

Parkinsonism - As with Parkinson's disease, this condition may involve ANY combination of tremors, postural unsteadiness, and rigidity of muscles in the limbs, neck, or trunk. Although the most common is a pill-rolling or alternating tremor of the hands, other kinds of tremors are occasionally seen. At times, a resident with Parkinsonism will have no tremor, only rigidity and shuffling gait. Symptoms respond to antiparkinson drugs, but not always completely. Dosage reduction or substitution of nonantipsychotic drug, when feasible, is the preferred management.

Akinesia - This condition is characterized by marked decrease in spontaneous movement, often accompanied by nonparticipation in activity and self-care. It is managed by reducing the antipsychotic drug or adding an antiparkinson drug.

Dystonia - This disorder is marked by holding of the neck or trunk in a rigid, unnatural posture. Usually the head is either hyperextended or turned to the side. The condition is uncomfortable and prompt treatment with an antiparkinson drug can be helpful.

Akathisia - The inability to sit still. The resident with this disorder is driven to constant movement, including pacing, rocking, or fidgeting, which can, at times persist for weeks, even after the antipsychotic drug is stopped. The condition responds occasionally to antiparkinson drugs, but less consistently than parkinsonism or dystonia. Sometimes benzodiazepines or beta-blockers are helpful in treating the symptom, although dosage reduction is the most desirable treatment when possible.

Tardive Dyskinesia - Persistent, sometimes permanent movements induced by long-term antipsychotic drug therapy. Most typical are thrusting movements of the tongue, movements of the lips, or chewing or puckering movements. These involuntary movements can clearly interfere with chewing and swallowing. When they do, the dyskinesia can be suppressed by

raising the dose of the antipsychotic drug, **but this will make the problem more permanent**. When possible, it is usually preferable to reduce or eliminate the antipsychotic drug, because the symptoms of dyskinesia will often decrease over time after drug discontinuation.

Other variations of tardive dyskinesia include abnormal limb movements, such as peculiar and recurrent postures of the hands and arms, or rocking or writhing trunk movements. There is no consistently effective treatment. Withdrawal of the antipsychotic drug leads to eventual reversal of the symptoms over many months, in about 50% of cases.

Clarifying Information if Gait Disturbance Present (other than that induced by antipsychotics)

Long-acting benzodiazepine antianxiety drugs have been implicated in increasing the risk of falls and consequent injury by producing disturbances of balance, gait, and positioning ability. They also produce marked sedation often manifested by short-term memory loss, decline in cognitive abilities, slurred speech, drowsiness in the morning/daytime sedation, and little/no activity involvement. If an antianxiety drug is needed to treat an anxiety disorder, a short-acting benzodiazepine or buspirone would be preferable to a long-acting benzodiazepine. Buspirone is nonsedating and takes several weeks to work. Dosage should be increased slowly.

Clarifying Information if Cognitive/Behavior Impairment Present

Acute Confusion/Delirium - The MDS items that tap the syndrome of acute confusion or delirium, can all be caused or aggravated by psychotropic drugs of any of the major classes. If the resident does not have acute confusion related to a medical illness or severe depression consider the psychotropic drug as a cause. The most helpful information in establishing a relationship is the linkage between starting the drug and the occurrence of the change in cognitive status.

Depression - Both anti-anxiety and antipsychotic drugs may cause symptoms of depression as a side effect, or may aggravate depression in a resident with a depressive disorder who receives these drugs rather than specific antidepressive therapy.

Hallucinations/Delusions - While these are often symptoms of mental illness, all of the major classes of psychotropic drugs can actually produce or aggravate hallucinations. The antidepressant drugs, the more anticholinergic antipsychotic drugs, and the shorter-acting benzodiazepines such as triazolam and lorazepam are most implicated in causing visual hallucinations. Visual hallucinations in the aged are virtually always indicative of brain related disturbance (e.g., delirium) rather than a psychiatric disorder.

Major Differences in AM/PM Self-Performance - All classes of psychotropic drugs can have an effect on a resident's ability to perform activities of daily living. Establishing a link between the times a drug is taken and the change in self-performance is helpful in evaluating the problem.

Decline in Cognition/Communication - Decline in these areas signals the possibility that the decline is drug-induced and the need to review the relationship of the decline with initiation or change in drug therapy. All major classes of psychotropics can cause impairment of memory and other cognitive skills in vulnerable residents. While memory loss in nursing facility residents is caused primarily by dementing disorders and other neurologic disease, psychotropic drugs, particularly those with anticholinergic side effects, and long-acting benzodiazepines, definitely contribute to memory impairment. In contrast, treatment of depression or psychosis can actually improve usable memory, which is very much disrupted by severe psychiatric illness. If memory worsens after initiating or increasing the dose of a psychotropic drug, consider reducing or discontinuing the drug, or substituting a less anticholinergic drug. For a resident with anxiety, a short-acting benzodiazepine or buspirone is preferable to a long-acting benzodiazepine.

Decline in Mood (See reference to Depression above)

Decline in Behavior - Problem behaviors may be aggravated and worsened by psychotropic drugs as they can contribute to confusion, perceptual difficulties, and agitation.

Decline in ADL Status - Drug side effects must always be considered if a resident becomes more dependent in ADLs. In addition, psychotropic drugs can precipitate or worsen bladder incontinence either through a change in cognition or through a direct action on bladder function.

Clarifying Issues if Drug-Related Discomfort Present

Dehydration; Reduced Dietary Bulk; Lack of Exercise

Constipation/Fecal Impaction - Any psychotropic drug with anticholinergic effects can cause or aggravate constipation; the effects are pronounced with tricyclic antidepressants and with low-potency antipsychotic drugs such as chlorpromazine or thioridizine. Milder cases of constipation can be treated with stool softeners, bulk-forming agents, and increased fluid; more severe constipation is best managed by substituting a less anticholinergic agent, or decreasing or discontinuing the psychotropic drug if possible. Antianxiety drugs can contribute to constipation if they sedate the resident to the point that fluid intake or exeresis is impaired. The problem can be handled by switching to a less sedating drug, decreasing dosage, or discontinuing the drug, if possible.

Urinary Retention - This condition may be manifested by the inability to urinate, or new onset or worsening of urinary incontinence (caused by overflow of urine from a full bladder that cannot empty properly). Any psychotropic drug with anticholinergic properties can produce or aggravate urinary retention. The problem is best managed by substituting a less anticholinergic agent, or decreasing or discontinuing the psychotropic drug if possible.

Dry Mouth - This symptom is a common side effect of any psychotropic drug with anticholinergic properties. Dry mouth can aggravate chewing and swallowing problems. Substituting a less anticholinergic drug may be helpful. Other remedies include artificial saliva or sugar-free mints or candies (sugar contributes to cavity formation).

WHEN TO DISCONTINUE DRUG TREATMENT

1. Drug treatment that is ineffective after a reasonable trial should be discontinued or changed. The definition of a reasonable trial depends on the drug class and therapeutic indication.

2. When a medication is effective, but produces troublesome side effects, either the dose should be reduced or the medication should be replaced, with a therapeutically equivalent agent less likely to cause the problematic side effect. If this is not feasible, or if doing it leads to a recurrence of symptoms, specific medical therapy for the troublesome side effects should be considered. For example, if the best drug for treating a resident's depression causes constipation, stool softeners, laxatives, or bulk-forming agents can be prescribed.

3. When a medication is effective and does not cause troublesome side effects, it should be continued for a defined period, and then efforts should be made to taper and eventually discontinue the drug.

4. Psychotropic medication should be prescribed on a permanent basis only if symptoms have recurred on at least two previous attempts to taper the medication after a defined period of therapy.

COMMONLY PRESCRIBED PSYCHOTROPIC DRUGS AND THEIR SIDE EFFECTS

TABLE A. ANTIPSYCHOTIC (NEUROLEPTIC) DRUGS

Generic Name	Brand Name	Incidence of Side Effects			
		Sedation	Hypotension	Anti-cholinergic Symptoms[1]	Extra-pyramidal Symptoms[2]
Chlorpromazine	Thorazine	Marked	Marked	Marked	Mild
Thioridazine	Mellaril	Marked	Marked	Marked	Mild
Acetophenazine	Tindal	Mild	Mild	Moderate	Mild
Perphenazine	Trilafon	Mild	Mild	Moderate	Moderate
Loxapine	Loxitane	Mild	Mild	Moderate	Moderate
Molindone	Moban	Mild	Mild	Moderate	Moderate
Trifluoperazine	Stelazine	Mild	Mild	Mild	Marked
Thiothixene	Navane	Mild	Mild	Mild	Marked
Fluphenazine	Prolixin	Mild	Mild	Mild	Marked
Haloperidol	Haldol	Minimal	Minimal	Mild	Marked

TABLE B. ANTIDEPRESSANT DRUGS

Generic Name	Brand Name	Incidence of Side Effects		
		Sedation	Hypotension	Anti-cholinergic Symptoms[1]
Cyclic antidepressants:				
Imipramine	Tofranil	Mild	Moderate	Mod-strong
Desipramine	Norpramin	Mild	Mild-mod	Mild
Doxepin	Adapin Sinequan	Mod-strong	Moderate	Strong
Amitriptyline	Elavil Triavil	Strong	Moderate	Very Strong
Nortriptyline	Aventyl Pamelor	Mild	Mild	Moderate
Maprotiline	Ludiomil	Mod-strong	Moderate	Moderate
Amoxapine*	Asendin	Mild	Moderate	Moderate
Fluoxetine	Prozac	Variable	Nil	Nil
Triazolopryridine Antidepressant:				
Trazodone	Desyrel	Mod-strong	Moderate	Mild
MAO inhibitors+:				
Phenelzine	Nardil	Mild	Moderate	Mild
Tranylcypromine	Parnate	Mild	Moderate	Mild
Other:				
Bupropion	Wellbutrin	None May cause agitation High incidence of seizures	Nil	Nil

COMMONLY PRESCRIBED PSYCHOTROPIC DRUGS AND THEIR SIDE EFFECTS (cont.)

TABLE C. ANTIANXIETY AND HYPNOTIC DRUGS

Generic Name	Brand Name	Duration of Action
Benzodiazepines:		
Triazolam	Halcion	Very short
Oxazepam	Serax	Short
Temazepam	Restoril	Short
Lorazepam	Ativan	Short
Alprazolam	Xanax	Medium
Chlordiazepoxide	Librium	Long
Diazepam	Valium	Long
Clorazepate	Tranxene	Long
Flurazepam	Dalmane	Very long
Barbiturates		
Antihistamines		
Diphenhydramine	Benadryl	Moderate
Hydroxyzine	Vistaril	Moderate
Chloral hydrate	Noctec	Long
Other:		
Buspirone	BuSpar	Not meaningful

* Also a neuroleptic drug with all the neuroleptic side effects.

\+ Special diet required; many drug interactions.

1 Anticholinergic symptoms include: dry mouth, constipation, urinary retention, blurred vision, confusion, disorientation, short-term memory loss, hallucinations, insomnia, agitation and restlessness, picking behaviors, fever.

2 Extrapyramidal symptoms include: movement disorder, such as Parkinsonism, dyskinesias, and akathisia (described in text).
Antidepressants (except Amoxapine) and antianxiety/hypnotics do not produce extrapyramidal side effects.

17. PSYCHOTROPIC DRUG USE RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

TO BE TRIGGERED, MUST FIRST USE PSYCHOTROPIC DRUG [Antipsychotic, antidepressant, or antianxiety] **[O4a, b, or c = 1-7]**

If used, go to RAP review if one of more of following present:

_____

Potential for drug-related hypotension or gait disturbances:

- Repetitive Physical Movements[a] **[E1n = 1, 2]**
- Balance While Sitting **[G3b = 1, 2, 3]**
- Hypotention **[I1i = checked]**
- Dizziness/Vertigo[b] **[J1f = checked]**
- Syncope **[J1m = checked]**
- Unsteady Gait **[J1n = checked]**
- Fell in Past 30 Days[b] **[J4a = checked]**
- Fell in Past 31-180 Days[b] **[J4b = checked]**
- Hip Fracture **[J4c = checked]**
- Swallowing Problem **[K1b = checked]**

Potential for drug-related cognitive/behavioral impairment if:[c]

- **Delirium/Disordered Thinking**
  - Easily Distracted **[B5a = 2]**
  - Periods of Altered Perception or Awareness or Surroundings **[B5b = 2]**

_____

[a] **Note:** This items also triggers on the Mood RAP.

[b] **Note:** These items also trigger on the Falls RAP.

[c] **Note:** All of these items also trigger on the Delirium RAP.

GUIDELINES

If resident is triggered, review the following:

- **Drug Review [from record]:**
  - Length of Time Between when Drug First Taken and Onset of Problem;
  - Doses of Drug and How Frequently Taken;
  - Number of Classes of Psychotropics Taken;
  - Reason Drug Prescribed.

- **Review Resident's Condition that Affects Drug Metabolism/Excretion:**
  Impaired Liver/Renal Function **[I1qq, I3]**, Acute Condition **[J5b]**, Dehydration **[J1c]**

- **Review Behavior/Mood Status:**
  Current Problem Status **[E1, E2, E4]**, Recent Changes **[E3, E5]**, Behavior Management Program **[P1be, P2]**, Psychiatric Diagnoses **[I1dd,ee,ff,gg]**

Clarifying information if hypotension present:

- Postural Changes in Vital Signs **[from exam]**
- Drugs with Marked Anticholinergic Properties **[from record]**

Clarifying information if movement disorder present:

- High Fever **[J1h]** AND/OR Muscular Rigidity **[from record, observation]**
- Tremors, Especially of Hands; Pill-Rolling of Hands; Muscle Rigidity of Limbs, Neck Trunk (Parkinsonism) **[I1y; from record, observation]**
- Marked Decrease in Spontaneous Movement (Akinesia) **[from record, observation]**
- Rigid, Unnatural, Uncomfortable Posture of Neck or Trunk (Dystonia) **[from record, observation]**
- Restlessness, Inability to Sit Still (Akathisia) **[from record, observation]**
- Persistent Movements of the Mouth (e.g., Thrusting of Tongue, Movements of Lips, Chewing/Puckering) **AND/OR** Peculiar and Recurrent Postures of Limbs, Trunk (Tardive Dyskinesia) **[from record, observation]**

17. PSYCHOTROPIC DRUG USE RAP KEY (continued)

(For MDS Version 2.0)

TRIGGER – REVISION

Potential for drug-related cognitive/behavioral impairment if: [(c)] ***(continued)***

- Episodes of Disorganized Speech **[B5c = 2]**
- Periods of Restlessness **[B5d = 2]**
- Periods of Lethargy **[B5e = 2]**
- Mental Function Varies over the Course of the Day **[B5f = 2]**

- Deterioration in Cognitive Status[(c)] **[B6 = 2]**
- Deterioration in Communication **[C7 = 2]**
- Deterioration in Mood[(c)] **[E3 = 2]**
- Deterioration in Behavioral Symptoms[(c)] **[E5 = 2]**
- Depression **[I1ee = checked]**
- Hallucinations **[J1i = checked]**

Potential for drug-related discomfort if:

- Constipation **[H2b = checked]**
- Fecal Impaction **[H2d = checked]**
- Lung Aspiration **[J1k = checked]**

GUIDELINES

Clarifying information if gait disturbances present:

- Long-Acting Benzodiazepines **[from med record]**
  - Recent Dosage Increase **[from med record]**
- Short-Term Memory Loss, Decline in Cognition **[B6]**, Slurred Speech **[C5]**
- Decreased AM Wakefulness **[E1k, N1a]**, Little/No Activity Involvement **[N2]**

Clarifying information if cognitive/behavioral impairment present:

If <u>neither</u> of following are present, psychotropic drug side effects can be considered as a major cause of problem:

- Acute Confusion (Delirium) Related to Medical Illness **[B5[**
- Depression **[I1ee]**

Clarifying issues if drug-related discomfort present:

- Dehydration **[J1c]**, Reduced Dietary Bulk, Lack of Exercise **[from record]**, Constipation **[H2b[**, Fecal Impaction **[H2d]**, Urinary Retention **[I3; from record]**
- Other Potential Drug-Related Discomforts that May Require Resolution: Dry Mouth, if on Antipsychotic or Antidepressant **[observation]**

18. RESIDENT ASSESSMENT PROTOCOL: PHYSICAL RESTRAINTS

I. PROBLEM

Research and standards of practice show that the belief that restraints ensure safety is often unfounded. In practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use. Physical restraints not only may not prevent falls, but can cause greater harm including strangulation, loss of muscle tone, decreased bone density (with greater susceptibility for fractures), pressure sores, decreased mobility, depression, agitation, loss of dignity, incontinence, constipation, and in some cases, resident death. Benefits of refraining from the use of physical restraints have been well documented in long-term care literature; they include improvement in residents' quality of life, greater independence and functional capacity, use of fewer antipsychotic medications, less skin break down, and fewer serious injuries due to falls.

The experience of many health care providers suggests that facility goals can often be met without the use of physical restraints. In part, this involves identifying and treating health, functional, or psychosocial problems. This may be accomplished through resident care management alternatives, such as modifying the environment to make it safer; maintaining an individual's customary routine; using less intrusive methods of administering medications and nourishment; and recognizing and responding to residents' needs for psychosocial support, responsive health care, meaningful activities and regular exercise.

II. TRIGGERS

***Definition*:** Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body.

- Use of Trunk Restraint[(a)]
  [P4c = 1,2]
- Use of Limb Restraint
  [P4d = 1,2]
- Use of Chair that Prevents Rising
  [P4e = 1,2]

[(a)] **Note:** Code 2 also triggers on the Pressure Ulcer RAP. Both codes trigger on the Falls RAP.

III. GUIDELINES

In evaluating and reconsidering the use of restraints for a resident, consider needs, problems, conditions, or risk factors that, if addressed, could eliminate the need for using restraints. Refer to the RAP KEY for specific MDS items to consider as you review the following issues.

WHY ARE RESTRAINTS USED?

The first step in determining whether use of a restraint can be reduced or eliminated is to identify the reasons a restraint was applied.

- Review the resident's record and consult primary caregivers to determine the medical symptom that warrants the use of the restraint.

CMS Guidance: "**Medical Symptom**" is defined as an indication or characteristic of a physical or psychological condition. The resident's medical symptoms should not be viewed in isolation; rather the symptoms should be viewed in the context of the resident's condition, circumstances, and environment. Objective findings derived from clinical evaluation and the resident's subjective symptoms should be considered to determine the presence of the medical symptom. The resident's subjective symptoms may not be used as the sole basis for using a restraint. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of the restraint, and how the use of the restraint would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being. Medical symptoms that warrant the use of restraints must be documented in the resident's medical record, ongoing assessments, and care plans.

Ask the following questions:

- ***Why*** is the resident restrained?
- ***What type(s)*** of restraint is used?
- ***During what time of day*** is each type(s) used?
- ***Where*** is the resident restrained (e.g., own room in bed, chair in hallway)?
- ***How long*** is the resident restrained each day?
- ***Under what circumstances*** (e.g., when left alone, after family leave, when not involved in structured activity, when eating)?
- ***Who*** suggested that the resident be restrained (e.g., staff, family, resident)?

CONDITIONS ASSOCIATED WITH RESTRAINT USE

It may be possible to identify and resolve the phsycial or psychological condition that caused restraints to be used. By addressing the underlying condition(s) and cause(s), the facility may eliminate the medical symptom that warrants the use of the restraint(s). In addition, a review of underlying needs, risks, or problems may help to identify other potential kinds of treatments. After determining why a restraint is used, review the appropriate areas described below.

Problem Behavioral Symptoms

To determine the presence of a behavioral symptom, review the MDS. If the behavioral symptom for which the resident is restrained was not exhibited in the last 7 days, was it because the restraint prohibited the behavior from occurring (e.g., resident was restrained and

could not pull out the feeding tube). If a behavioral symptom was present during the last 7 days or the resident was restrained to prevent a behavioral symptom, consider the resident to have a behavioral symptom and review Behavioral Symptom RAP as indicated.

Risk of Falls

Although restraints have ***not*** been shown to safeguard residents from injury, one of the most common reasons given by facilities for restraining residents is to prevent falls. In some instances, restraints have been reported to contribute to falls and injuries. Because of the complications associated with restraint use, many physicians and geriatric clinicians recommend exploring alternatives for preventing falls, such as treating health problems and making environmental modifications.

Review risk factors for falls on RAP KEY. Refer to Falls RAP if these risks are present or if the restraint is being used to prevent falls.

Conditions and Treatments

Another reason facilities give for using restraints is to prevent a resident from removing tubes.

If the resident is being restrained to manage resistance to any type of tube or mechanical device (e.g., indwelling/external catheter, feeding tube, intravenous line, oxygen mask/cannula, wound dressing), review the following to facilitate decision-making:

- Is the tube/mechanical device used to treat a life-threatening condition?
- Does the resident actually need a particular intervention that may be potentially burdensome to him/her? Are there less intrusive treatment options?
- Why is the resident reacting to the tube/mechanical device with resistance? (e.g., Does the device produce discomfort or irritation? Is the resident really resisting or is the device just something to fidget with? Is the treatment compatible with the resident's wishes? Does the resident understand the reason for the method of treatment? Has the resident/family been informed about the risks and benefits of treatment options?)
- If an indwelling or external catheter is present, review the Urinary Incontinence RAP for alternatives.
- If a feeding tube is present, review the Feeding Tube RAP.

***CMS Guidance*:** If a resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed, unless the facility has a notice indication that the resident has previously made a valid refusal of the treatment in question.

ADL Self-Performance

In rare instances, a restraint can enhance a resident's ability to be more self-sufficient, IF the restraint use is supportive and time-limited.

Review the MDS, to determine if the restraint contributes to the resident's self-performance of an activity (e.g., wheelchair belt supports trunk while resident wheels self, geriatric chair used only at meals enables wandering resident to attend to feeding self).

Confounding Problems to be Considered

Many problem behaviors are manifestations of unmet health, functional, and/or psychosocial needs that can often be reduced, eliminated, or managed by addressing the conditions that produced them. (See RAP on Behavioral Symptoms). Conditions associated with behavioral symptoms and restraint use include:

- Delirium (a state of temporary mental confusion with an acute onset)
- Impaired Cognition
- Impaired Communication (e.g., difficulty making needs/wishes understood or understanding others)
- Unmet Psychosocial Needs (e.g., social isolation, disruption of familiar routines, anger with family members)
- Sad or Anxious Mood
- Resistance to Treatment, Medication, Nourishment
- Psychotropic Drug Side Effects (e.g., motor agitation, confusion, gait disturbance)
- If a behavior management program is in place, does it adequately address the causes of the resident's particular problem behaviors?

OTHER FACTORS TO BE CONSIDERED

Resident's Response to Restraints

In evaluating restraint use, it is important to review the resident's reaction to restraints (e.g., positive and negative, such as passivity, anger, increased agitation, withdrawal, pleas for release, calls for help, constant attempts to untie/release self). This will help determine whether or not presumed benefits are outweighed by negative side effects.

Review MDS items for other potential negative effects of restraint use, such as declines in functional self-performance, body control, skin condition, mood or cognition that may have occurred since the physical restraint was initiated.

Alternatives to Restraints

Many interventions may be as effective or even more effective than physical restraints in managing a resident's needs, safety risks, and problems. To be effective the intervention must address the underlying problem.

- Review resident's record and confer with staff to determine whether or not alternatives to restraints have been tried.
- If alternatives to restraints have been tried, what were they?

- How long were the alternatives tried?
- What was the resident's response to the alternatives at the time?
- If the alternative(s) attempted were ineffective, what else was attempted?
- How recently were alternatives other than restraints attempted?

Philosophy and Attitudes

CMS Guidance: In order for a resident to be fully informed, the facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration, including using a restraint, not using a restraint, and alternatives to restraint use. Whenever restraint use is considered, the facility must explain to the resident how the use of restraints would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical or psychological well-being. In addition, the facility must explain the potential negative outcomes of restraint use. In the case of a resident who is incapable of making a decision, the legal surrogate or representative may exercise this right based on the same information that would have been provided to the resident. However, the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when a restraint is not necessary to treat the resident's medical symptom. That is, the facility may not use restraints in violation or the regulations solely based on a legal surrogate or representative's request or approval. While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand the facility use specific medical interventions or treatments that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions.

18. PHYSICAL RESTRAINTS RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

Review for efficacy, side effects and alternatives if one of more of the following:

- Use of Trunk Restraint[(a)]
  [P4c = 1, 2]
- Use of Limb Restraint
  [P4d = 1, 2]
- Use of Chair that Prevents Rising
  [P4e = 1, 2]

GUIDELINES

Review factors and complications associated with restraint use:

- **Behavioral Symptoms:** Repetitive Physical Movements **[E1n]**, Any Behavioral Symptoms **[E4]**, Part of Behavior Management Program **[P1be, P2; from record]**

- **Risk of Falls:** Dizziness **[J1f]**, Falls **[J4a, b]**, Antianxiety **[O4b]**, Antidepressant **[O4c]**

- **Conditions and Treatments:** Catheter **[H3c, d]**, Hip Fracture **[J4c, I1m]**, Unstable/Acute Condition **[J5a, b]**, Parenteral/IV and/or Feeding Tube **[K5a, b]**, Wound Care/Treatment **[M5f, g, h, i]**, IV Meds **[P1ac]**, Respirator/Oxygen **[P1ag, P1al]**

- **ADL Self Performance [G1]**

Confounding Problems to be Considered:

- Delirium **[B5]**
- Cognitive Loss/Dementia **[B2, B4]**
- Impaired Communication **[C4, C6]**
- Sad/Anxious Mood **[E1, E2]**
- Resistance to Treatment/Meds/Nourishment **[E4e]**
- Unmet Psychosocial Needs **[F1, F2, F3]**
- Psychotropic Drug Side Effects **[see record, J1e, f, h, i, m, n]**

- **Other Factors to be Considered:** Resident's Response to Restraint(s); Use of Alternatives to Restraints; Resident/Family/Staff Philosophy, Values, Wishes, Attitudes About Restraints **[record, observation, discussion]**

[(a)] **Note:** Code 2 also triggers on the Pressure Ulcer RAP. Both codes trigger on the Falls RAP.

APPENDIX D

INTERVIEWING TECHNIQUES

Interviewing Techniques

Performing an accurate and comprehensive assessment requires that the assessor communicate effectively with a number of individuals. An individual assessor may use the following suggestions to obtain information from residents, facility staff and resident families. There are other possible models for resident data collection and interviewing, especially when conducted by a team, which you may want to consider in your specific facility.

When conducting any interview to collect information in the RAI process, there are some general concepts that you should consider.

First, emphasize to all individuals that during your interview (i.e., residents, families and staff) that the RAI process is a way to "get to know the resident." You should explain that the RAI assessment provides valuable information that will be used by facility staff to develop the resident's care plan. This is an opportunity to bring residents and families into the assessment and care planning process.

Second, be flexible as to how you conduct the RAI process with each resident. It is not necessary for you to complete the assessment in the same order sequence as sections appear on the MDS form. The MDS is not a questionnaire; it is a set of common items and definitions for assessment, which provides a structure for systematically recording the information you obtain. You should let the resident's needs guide you during the assessment process.

You may wish to use the following general techniques, if appropriate, when conducting interviews:

To elicit complete and satisfactory answers, you will often need to ask neutral or nondirective questions. **Examples are:**

- "What do you mean?"
- "Tell me what you have in mind."
- "Tell me more about that."
- "Please be more specific."
- "Give me an example."

Repeat a question if you think it has been misunderstood or misinterpreted.

Pause or hesitate to indicate that you are listening and need more or better information. This is a good technique to use while you are determining the individual's response pattern.

Some items will require special sensitivity during the questioning process (e.g., the MDS items in Section B dealing with memory), and you should note the instructions in Chapter 3 on how to assess each item or gather the information to respond to each item.

Some respondents may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic. For example you may say:

- "That's interesting."
- "Now I need to know..."

- "Let's get back to..."
- "Tell me about..."

Validate your understanding of what a respondent is saying. Be careful that you do not appear to be challenging a respondent when clarifying a statement. For example you may say:

- "I think I hear you saying that..."
- "Let's see if I understood you correctly."
- "You said ... Is that right?"

When respondents (resident/family/caregivers) disagree or when a resident (who you believe is capable of rational judgment) says something contrary to information contained in the record, you should clarify the information. Ultimately, use your best clinical judgment to weigh all information.

Consider developing and using a printed questionnaire to help residents and families contribute important information (e.g., Customary Routine).

Finally and most importantly, validate with the resident, through observations or interview, what you have heard from other facility staff, family members or what you have read in the record.

When collecting information from facility staff there are other important considerations that may make the process easier and more efficient.

You should respect the professional status of staff. Consider their need to perform their other duties in addition to providing necessary assessment information for you. The following suggestions may assist you when conducting facility staff interviews:

1. Post a schedule of residents who are being assessed during a given period (e.g., month) so that staff can prepare to participate in the assessment.

2. Provide prior notice to other staff members that an assessment is due, giving direct care staff an opportunity to gather their thoughts about residents. You may wish to provide a worksheet that staff (e.g., nursing assistants) could use to note particular resident information (e.g., ADLs).

3. Schedule interviews in advance, at mutually convenient times; avoid busy workload times.

4. Know what you want to cover. Leave a few minutes for staff to provide open-ended comments that may pertain to the well-being of the resident.

5. Provide other staff members with a list of areas you wish to cover to expedite the process.

6. Key your questions to the time period for which resident performance is being assessed.

You will often need to discuss a resident with more than one facility staff member. For example, an individual staff member who has been on a 3-week vacation may recall the resident's function a month ago instead of during the last 7 days. A nurse that floats from unit to unit may not know the residents well enough to respond appropriately. If a facility staff respondent struggles with answers or seems vague in referring to the time period in question, you should consider seeking another respondent.

Reinforce to all staff at the onset of the interview that you are gathering information to learn as much about the resident as possible to best plan for the resident's care. Reassure any staff that your purpose is the RAI process and not an evaluation of their job performance.

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APPENDIX E

COMMONLY PRESCRIBED MEDICATIONS BY CATEGORY BY BRAND (GENERIC)

Commonly Prescribed Medications
By Category By Brand (Generic)

Antipsychotics
Clozaril (Clozapine)
Haldol (Haloperidol)
Inapsine (Droperidol)
Loxitane (Loxapine)
Mellaril (Thioridazine)
Moban (Molindone)
Navane (Thiothixene)
Orap (Pimozide)
Prolixin (Fluphenazine)
Serentil (Mesoridazine)
Sparine (Promazine)
Stelazine (Trifluoperazine)
Taractan (Chlorprothixene)
Thorazine (Chlorpromazine)
Tindal (Acetophenazine)
Trilafon (Perphenazine)
Vesprin (Triflupromazine)

Antidepressants
Adapin (Doxepin)
Asendin (Amoxapine)
Aventyl, Pamelor (Nortriptyline)
Desyrel (Trazodone)
Elavil (Amitriptyline)
Lithonate, Lithane (Lithium)
Ludiomil (Maprotiline)
Marplan (Isocarboxazid)
Nardil (Phenelzine)
Norpramin (Desipramine)
Pamelor (Nortriptyline)
Parnate (Tranylcypromine)
Prozac (Fluoxetine)
Sinequan (Doxepin)
Surmontil (Trimipramine)
Tofranil (Imipramine)
Vivactil (Protriptyline)
Wellbutrin (Bupropion)
Zoloft (Sertraline)

Antianxiety
(Phenobarbital)
Anytal (Amobarbital)
Atarax (Hydroxyzine)
Ativan (Lorazepam)
Buspar (Buspirone)
Centrax (Prazepam)
Doriden (Glutethimide)
Equanil, Miltown (Meprobamate)
Librium (Chlordiazepoxide)
Noctec (Chloral Hydrate)
Noludar (Methyprylon)
Paxipam (Halazepam)
Serax (Oxazepam)Tranxene (Clorazepate)
Tranxene (Clorazepate)
Valium (Diazepam)
Vistaril (Hydroxyzine)
Xanax (Alprazolam)

Hypnotics
Alurate (Aprobarbital)
Dalmane (Flurazepam)
Doral (Quazepam)
Halcion (Triazolam)
Nembutal (Pentobarbital)
Placidyl (Ethchlorvynol)
ProSom (Estazolam)
Restoril (Temazepam)
Seconal (Secobarbital)

Diuretics
This list includes example of diuretics (brand name and generic equivalents) likely to be used in a nursing facility population. This list is not inclusive; consult your pharmacist, the resident's physician, or a drug reference manual, as necessary.

Brand (generic)
Aldactazide (spironolactone/hydrochlorothiazide
Aldactone (Spironolactone)
Aqua-Ban
Aquatensen (Methyclothiazide)
Bumex (Bumetanide)
Diamox (Acetazolamide)
Diuril (Chlorothiazide)
Dyazide (Triamterene/hydrochlorothiazide)

Dyrenium (Triamterene)
Edecrin (Ethacrynic Acid)
Enduron (Methyclothiazide)
Esidrix (Hydrochlorothiazide)
Hydrodiuril (Hydrochlorothiazide)
Hydromox (Quinethazone)
Hygroton (Chlorthalidone)
Lasix (Furosemide)
Lozol (Indepamide)
Mannitol (Mannitol)
Maxzide (Triameterene/hydrochlorothiazide)
Midamor (Amiloride)
Moduretic (Amiloride HC1/hydrochlorothiazide)
Neptazane (Methazolamide)
Oretic (Hydrochlorothiazide)
Zaroxolyn (Metolazone)